12 Months:

## **NEW EMPANELMENT REQUEST FORM**



Submission Date: 03/05/2015 Requesting Facility: **↓**|MRUN: Find Patient's Name: Last: First: MI: Patient's DOB: Patient's Preferred Patient's Phone: Email: Patient Address: Address: City: State: Zip Code: Patient's Gender: Patient's Preferred Language: Patient hasHIV/AIDS Patient is Severe physical disability appropriate for Rancho Los Amigos PCMH Preferred PCMH Location Any Location (DHS or Community Partner)\*: Preferred PCMH Provider No Preference (DHS or Community Partner)\*: Name of person completing this Raymond Rodriguez form: Requestor's Phone #: Requestor's DHS E-mail: @dhs.lacounty.gov Name of Requesting Provider\*: Requesting Provider's Phone #: Req. Provider's @dhs.lacounty.gov DHS Email\*: Chronic (Ambulatory Care Sensitive) Conditions: V • # of Inpatient Admissions # of Emergency # of Urgent Care and # of Specialties Seen Walk-in Visits **Department Encounters** DHS Non-DHS DHS Non-DHS DHS Non-DHS DHS Non-DHS Within the Past